No. 07-508

In The Supreme Court of the United States

BRENDA L. MORGAN, individually and as Personal Representative of the Estate of Thomas Henry Morgan, Sr., Deceased,

Petitioner,

v.

NORTH MISSISSIPPI MEDICAL CENTER, INC., a Delaware Corporation,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

BRIEF IN OPPOSITION

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QUESTION PRESENTED

1. Absent evidence of a "ruse" or "subterfuge" to avert EMTALA obligations, whether potential EMTALA liability, consistent with 42 C.F.R. § 489.24(d)(2)(i) and other established precedent, ceases on inpatient admission to the hospital from the emergency department.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 29.6 of the Rules of the Court, Respondent states the following: North Mississippi Medical Center, Inc., is wholly owned by North Mississippi Health Services, Inc., a not-for profit Delaware Corporation.

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STATEMENT OF THE CASE

A. Course of the Proceedings

On August 26, 2005, Petitioner commenced this action in the United States District Court of the Southern District of Alabama by filing a complaint as Personal Representative of her deceased husband, Thomas Henry Morgan, Sr. ("Mr. Morgan"). Petitioner's complaint alleged that North Mississippi Medical Center, Inc. ("NMMC"), violated the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd ("EMTALA") and engaged in conduct constituting the common law tort of outrage in Alabama.

On October 10, 2005, NMMC filed a Rule 12 motion to dismiss plaintiff's complaint for failure to state a claim under EMTALA.

On December 2, 2005, the District Court granted NMMC's motion and dismissed that portion of Petitioner's EMTALA claim predicated upon an alleged violation of EMTALA's "medical screening" requirement. The District Court denied NMMC's motion to dismiss Petitioner's EMTALA "stabilization" claim, in part, based exclusively upon "a fair reading of the complaint support[ing] a subterfuge theory of liability." As a result, Morgan's only remaining EMTALA claim, as of December 2, 2005, was a claim alleging a "ruse" or "subterfuge" surrounding the inpatient admission of Mr. Morgan from the NMMC emergency department to a private hospital room on August 22, 2003.

On August 18, 2006, NMMC filed a motion for summary judgment. After full briefing by the parties, the District Court entered an order granting summary judgment on October 12, 2006, and entered a final judgment dismissing Petitioner's remaining claims with prejudice.

On November 13, 2006, Petitioner filed her notice of appeal to the United States Court of Appeals for the Eleventh Circuit. A panel of the Eleventh Circuit Court of Appeals heard oral argument on May 17, 2007.

On May 21, 2007, the Eleventh Circuit Court of Appeals affirmed the summary judgment in favor of NMMC in a per curiam opinion and expressly referenced the "well-reasoned orders" of the District Court previously entered on December 2, 2005, and October 12, 2006.

On June 8, 2007, Petitioner filed a Petition for Rehearing En Banc, which was denied by the Eleventh Circuit Court of Appeals on July 17, 2007.

Petitioner now seeks review of the per curiam decision of the Eleventh Circuit Court of Appeals which affirmed the District Court's summary judgment in favor of NMMC on all claims.

B. Statement of Facts

The complete and accurate[1] operative facts herein are as follows:

Thomas Henry Morgan, Sr. ("Mr. Morgan"), died at his home in Foley, Alabama, in the early morning hours of September 1, 2003. (Appendix C, pp. 4a-5a, 17a) Ten days before his death, on August 22, 2003, Mr. Morgan accidentally fell from a stand at his hunting camp outside Calhoun City, Mississippi, and sustained multiple blunt force trauma injuries as a result. (Appendix C, p. 5a) North Mississippi Medical Center ("NMMC") accepted Mr. Morgan for evaluation and treatment in its emergency department in Tupelo, Mississippi, as an emergency transfer patient from Calhoun City Hospital in Calhoun City, Mississippi. (Appendix C, p. 6a)

Mr. Morgan presented to the NMMC emergency department with complaints of severe right shoulder pain, severe right back pain, chest pain, and shortness of breath. (Appendix C, p. 7a) Upon Mr. Morgan's arrival at NMMC, he received substantial diagnostic testing and treatment in the NMMC emergency department in accord with the hospital's trauma protocol over the course of nearly four and a half hours at a cost exceeding $8,000. His treatment included a battery of x-rays, consultations with

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[1] Petitioner's statement of facts includes inaccuracies and/or misstatements, which are addressed as necessary by footnote below.

doctors from multiple disciplines, a right shoulder reduction, pain management, and nursing care and monitoring. (Appendix C, p. 7a) Upon consultation with an on-call general surgeon, Dr. Linda Haigh, Mr. Morgan was admitted "in improved condition" to a private room[2] for inpatient care and services at NMMC. (*Id.*)

Mr. Morgan remained a patient at NMMC for nine days, receiving further medical care and treatment at additional costs totaling $24,000 over the entire course of his care at NMMC. (Appendix C, pp. 12a, 21a, 33a) During his inpatient admission, Mr. Morgan was evaluated and treated by five different physicians specializing in at least four different disciplines including (1) a neurosurgeon; (2) an anesthesiologist who specializes in pain management; (3) an orthopedic surgeon; and (4) two different general surgeons. (Appendix C, pp. 6a-12a) During his inpatient admission, Mr. Morgan received daily nursing care and monitoring services, physical therapy services, urinary/continence care, nutritional/hydration care, a second surgical procedure on his right shoulder, pain management, and additional diagnostic testing. (*Id.*)

Mr. Morgan's emergency room care and his inpatient admission orders all occurred *before* the NMMC business office ever discussed payment options with

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[2] The cost of a private room is $380.00 per day, which is more than a semi-private room. (Appendix C, p. 12a)

Mr. Morgan's wife, the Petitioner. (Appendix C, p. 12a) On Saturday morning, August 23, 2003, Petitioner met with an NMMC business office employee scheduled to work during regular Saturday business office hours. (Appendix C, pp. 12a-13a) At that time, NMMC inquired regarding the payment method for services and noted that Mr. Morgan did not have insurance. (Appendix C, pp. 12a, 33a) Mr. Morgan's treating physician, Dr. Linda Haigh, gave uncontroverted testimony that the patient's financial file is "generally not part of the medical record," and that she never had any idea, one way or the other, whether or not Mr. Morgan had insurance or other financial means to pay for the services provided to him at NMMC. (Appendix C, pp. 13a, 32a) After Petitioner's meeting with the NMMC business office, Mr. Morgan received an additional eight days of care and services at NMMC exceeding $16,000.

Mr. Morgan's care and treatment at NMMC included pain medication, physical therapy, and an epidural injection for lower back pain, all of which constitute care for compression fractures of the spine.[3] (Appendix C, p. 27a-28a) While Dr. Haigh

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[3] Petitioner misstates the uncontested record in her summary of the underlying facts, by claiming on page 5 of her Petition: "NMMC provided no treatment to stabilize this known medical condition [i.e., compression fractures]. In fact, no course of treatment was ever provided to stabilize this emergency medical condition." As outlined in detail by the District Court (Appendix C, pp. 10a-11a & n.7, 26a-28a), Petitioner's contention is *not* supported by the record.

became aware of and ordered treatment for Mr. Morgan's symptoms associated with compression fractures, she did not believe other treatment was necessary since, in her professional medical opinion, the compression fractures were pre-existing or "old" injuries, and were non-displaced. (Appendix C, pp. 10a-11a & n.7, 26a-27a & n.18) Dr. Haigh believed that Mr. Morgan's unwillingness to cooperate with physical therapy and extended stay in the hospital put him at risk for life threatening conditions, including pneumonia and blood clots. (Appendix C, p. 21a) Dr. Haigh expressed these medical concerns to the Petitioner prior to Mr. Morgan's discharge. (Appendix C, p. 16a) Dr. Haigh also ordered an MRI of Mr. Morgan's lower back, but the MRI was not done because Mr. Morgan refused it, desiring instead to go home to follow up with his primary treating physicians in Alabama. (Appendix C, pp. 11a, 21a, 27a-28a)

Dr. Haigh discharged Mr. Morgan from the hospital on Sunday, August 31, 2003, by and through her private practice associate, Dr. Raymond Orgler (a general surgeon), who was covering for Dr. Haigh over the weekend. (Appendix C, p. 16a) In anticipation of discharge, Dr. Haigh's colleague, Dr. Southworth (an orthopedist), spoke with Mr. Morgan's physicians in Foley, Alabama to assure continuity of care. (Appendix C, pp. 16a-17a & n.13)

Upon his discharge from the hospital, Mr. Morgan was transported by NMMC's ambulance service to his home in Foley, Alabama. (Appendix C, p. 17a) After his arrival at home in Foley, Alabama, Mr.

Morgan complemented the NMMC ambulance personnel and insisted his wife pay a "tip" to them for their services – a gesture that the NMMC ambulance attendants reluctantly accepted only at Petitioner's insistence. (*Id.*)

Mr. Morgan died at home in the early morning hours of Monday, September 1, 2003, as a result of complications of his medical condition(s), including a pulmonary embolus and organizing pneumonia (medical conditions Dr. Haigh was previously concerned about as risks of extended convalescence in a hospital setting, risks that she communicated to Mr. Morgan and Petitioner). (Appendix C, pp. 17a-18a, 21a)

SUMMARY OF THE ARGUMENT

This Court and all Circuit Courts agree that EMTALA is not a federal malpractice statute, and that it is not designed to preempt state malpractice law or other state tort remedies. The undisputed facts in this case amount, at best, to a potential claim for medical malpractice, but do not constitute a viable claim under EMTALA. Because the Petitioner did not otherwise plead (and certainly could not prove) a viable EMTALA claim, the District Court found that the only way the Petitioner might sustain a claim under EMTALA was to demonstrate that Mr. Morgan's admission to the hospital for inpatient care and services was a mere "ruse" or "subterfuge" to avoid

EMTALA liability. Independent from, yet consistent with, the Final Rule adopted by CMS regarding inpatient admissions to a hospital, the District Court ruled that EMTALA liability did not attach to inpatient admissions to the hospital unless the hospital admission was a sham designed to avoid EMTALA liability. As such, the District Court's ruling in this case is distinct from the central issue and ruling of this Court in *Roberts v. Galen of Virginia*, 525 U.S. 249 (1999), which held that "improper motive" is not an element of a viable claim under EMTALA. Rather, the District Court took up the question of *when* EMTALA liability ceases, as opposed to *what* elements otherwise constitute a legitimate EMTALA claim. *Roberts v. Galen* remains unaffected by the District Court's ruling in this case. The Petitioner also claims that the District Court held that knowledge of an emergency medical condition could only be inferred to a hospital by and through the patient's treating physician. The District Court's ruling did not include any such holding, and the Petitioner's assertion of this point is so overreaching and inaccurate that it constitutes a misstatement of the law and issues. In addition to proffering no evidence to otherwise support a viable claim under EMTALA, the uncontested facts herein affirmatively demonstrate nine days of inpatient care and services for Mr. Morgan that verify the sincerity of his inpatient admission and subsequent treatment at NMMC. There are no conflicts that warrant review by this Court and

the underlying facts in this case do not constitute a viable EMTALA claim under any circumstance.

REASONS FOR DENYING THE WRIT

A. The District Court's ruling, as affirmed by the Eleventh Circuit, does not conflict with *Roberts v. Galen of Virginia*.

Petitioner attempts to "red flag" this case by asserting that the Eleventh Circuit's affirmation of the District Court's ruling conflicts with this Court's decision in *Roberts v. Galen of Virginia*, 525 U.S. 249 (1999). There is no conflict.

The Center for Medicare and Medicaid Services ("CMS"), when commenting on the Final Rule adopted under EMTALA, indicated its familiarity with and consideration of *Roberts v. Galen*, stating:

> In *Roberts*, the Court addressed the issue of whether an individual must prove that a hospital acted with an improper motive in failing to stabilize that individual and concluded that the stabilization provision . . . contained no such requirement. The Court *did not* address the issue of *when* a hospital's EMTALA obligation to stabilize an individual ends.

(Appendix H, p. 108a) (emphasis added) In the present case, the issue before the District Court on summary judgment was *when* a hospital's EMTALA liability ends. More specifically, the District Court

ruled consistent with the Final Rule at 42 C.F.R. § 489.24(d)(2)(i), which states:

> If a hospital has screened an individual . . . and found the individual to have an emergency medical condition, and *admits* that individual as an *inpatient in good faith* in order to stabilize the emergency medical condition, *the hospital has satisfied its special responsibilities* [under EMTALA] with respect to that individual.

(Appendix I, p. 125a) (emphasis added)

The implicit fact that the patient in *Roberts* was apparently admitted for several weeks as an inpatient to a healthcare facility does not create a conflict of law, since the question of *when* EMTALA liability ends *was not* the issue before this Court in *Roberts*. *See Roberts* at 251 (noting the patient's six-week stay at a healthcare facility). The issue in *Roberts* was whether proof of improper motive surrounding transfer or discharge (such as the sex, race, or the ability of the patient to pay for services rendered) was required as an element of proof generally in order to sustain an EMTALA violation. *See id.* at 253-54. *Roberts* held that EMTALA's statutory language does not require such proof to sustain a claim under EMTALA. *Id.* at 253. Unlike *Roberts*, the primary issue before the District Court in the instant case was *when* EMTALA liability abates. Whether NMMC abused the inpatient admission process as a means to avoid EMTALA liability was merely a derivative or secondary consideration in the instant case based on the District

Court's ruling that EMTALA liability ceased on inpatient admission to the hospital in the absence of bad faith. (Appendix D, p. 63a)

Consistent with 42 C.F.R. § 489.24(d)(2)(i), the District Court held that EMTALA liability ends *when* an individual is admitted as an inpatient to the hospital unless that admission was a mere "ruse" or "subterfuge" designed to avert EMTALA liability. (*Id.*) However, in those cases in which EMTALA's obligations attach, neither CMS in the Final Rule nor the Eleventh Circuit's affirmation of the District Court in this case creates any additional obligation on patients to prove improper motive. By contrast in *Roberts*, this Court was asked to include motive or intent as a primary and essential element of a statutory claim under EMTALA. This Court refused that proposition in *Roberts*, and that ruling remains unencumbered by the Eleventh Circuit's affirmation of the District Court in this case. *See, e.g., Mazurkiewicz v. Doylestown Hosp.*, 305 F.Supp.2d 437, 447-48, n.10 (E.D. Pa. 2004) (holding that "admission is a defense as long as admission is not a subterfuge and stating that its holding was "not, however, a requirement that bad faith be proven to recover under EMTALA").

B. There is no conflict among the Circuits as to when a hospital has knowledge of an emergency medical condition, and the Eleventh Circuit's affirmation of the District Court in this case does not create any such conflict.

Petitioner poses a "red herring" question and misstatement of law to this Court by asserting that there is now a conflict among the Circuits as to when, in an EMTALA context, a hospital possesses knowledge of an emergency medical condition. There is no conflict, and no such conflict can be inferred from the District Court's summary judgment opinion in this case or the record herein. It is obvious and plain on the face of 42 U.S.C. § 1395dd(b) that it is "the hospital" that "determines" whether or not the patient has an emergency medical condition, such that any employee of the hospital can obtain the knowledge that might form such a determination. (Appendix F, p. 68a) The Sixth Circuit's plain reading and application of 42 U.S.C. § 1395dd(b) in *Roberts ex rel. Johnson v. Galen of Virginia*, 325 F.3d 776, 788 (6th Cir. 2003) remains unaffected by the District Court's decision in this case, since the District Court *did not* hold that knowledge could only be inferred to a hospital through a treating physician.

NMMC has *never* taken the position in this case that Mr. Morgan did not present to its emergency department with emergency medical conditions. To the contrary, he was screened, diagnosed, and treated for his emergency conditions upon presentation to

NMMC. NMMC agrees that knowledge of Mr. Morgan's compression fractures can be inferred to NMMC. Moreover, Petitioner concedes that the treating physician, Dr. Haigh, also became aware of the compression fractures during Mr. Morgan's admission to NMMC. (Petition, p. 3) As such, NMMC's knowledge (or lack thereof) regarding Mr. Morgan's compression fractures is not, and has never been, an issue in this case.

To the extent that Dr. Emig (a radiologist), Dr. Haigh (a general surgeon), and, consequently, NMMC, had a duty to act on the knowledge that Mr. Morgan had compression fractures, the undisputed facts reveal that Dr. Haigh regarded treatment of the compression fractures (other than pain management and physical therapy) as unnecessary based upon her professional medical judgment that the fractures were "old" and not secondary to Mr. Morgan's recent fall. (Appendix C, pp. 10a-11a & n.7, 26a-27a) Petitioner's contention that Dr. Haigh "provided no treatment to stabilize" Mr. Morgan's compression fractures is a misstatement that is not supported by the uncontroverted record. (Petition, p. 3)

Petitioner's contention that the Eleventh Circuit "held that a hospital can only be liable under EMTALA if the physician responsible for the patient's admission knew of the patient's emergency medical condition," is a statement that *does not* appear anywhere in the District Court's opinion affirmed by the Eleventh Circuit. (Petition, p. 26) This alleged "holding" is a forced inference that the Petitioner attempts

to draw from the District Court's opinion in a further attempt to "red flag" this case for review. While the District Court considered Dr. Haigh's knowledge regarding the compression fractures in its analysis, the District Court's actual holding was that Dr. Haigh's aggregate efforts to treat Mr. Morgan's known compression fractures dealt a "crushing blow" to plaintiff's EMTALA claim, in that the adequacy or inadequacy of such treatment was a matter for state tort law, not a federal anti-dumping statute. (Appendix C, pp. 26a-27a) Because Petitioner's contention that there is a conflict among the Circuits on this issue is a misstatement of the law and the issues in this case, Petitioner's arguments for review of this point are without merit.

C. The Final Rule published by CMS adequately clarifies any perceived conflict among the Circuits regarding when EMTALA liability ends.

The District Court's adoption of an approach consistent with the Final Rule is neither novel, nor controversial. On September 9, 2003, CMS clarified the Final Rule adopted under EMTALA, providing clear and consistent guidance to hospitals in cases where patients are not transferred or discharged from an emergency department within the meaning of EMTALA, but are instead admitted to the hospital as inpatients. *See* 42 C.F.R. § 489.24(d)(2)(i) (Appendix I, p. 125a and Appendix H, pp. 97a-102a) This

clarification alleviates the need for review of any prior conflict among the Circuit Courts.

Prior to CMS' clarification of the Final Rule on September 9, 2003, at least two Circuits had already come to the same conclusion that CMS reached when adopting the Final Rule. *See Bryant v. Adventist Health Systems/West*, 289 F.3d 1162, 1169 (9th Cir. 2002) (holding that EMTALA's obligations end on inpatient admission, unless the patient is admitted as a mere ruse to avoid EMTALA liability) and *Harry v. Marchant*, 291 F.3d 767, 775 (11th Cir. 2002), Barkett, J., *concurring* (stating that "because [the patient] was admitted as an [in]patient, redress for negligence occurring during her emergency room care is available through state malpractice laws, rather than federal law").

CMS considered, summarized and directly addressed any prior conflict among the Circuits when it clarified the Rule regarding when EMTALA liability ends. *See* 68 Fed. Reg. 53222 (Appendix H, p. 99a) Even though CMS did not adopt the Final Rule until shortly after Mr. Morgan's discharge from NMMC, the Eleventh Circuit's affirmation of the District Court's opinion in this case *did not* exclusively rely on the Final Rule. Moreover, while the Final Rule is instructive and persuasive, it is not binding on the Court. As such, the District Court cited the Final Rule as persuasive authority, but appropriately treated the Final Rule as a guide, not a mandate. (Appendix D, p. 63a n.37) Instead, the District Court's "well-reasoned" opinion at the 12(b)(6) stage of review

considered the varying approaches of the Circuit Courts prior to amendment of the Final Rule, and the District Court settled on the holding of the Ninth Circuit in *Bryant*, which happens to be consistent with the approach taken by CMS when adopting the Final Rule. (Appendix D, pp. 60a-63a) *See also, Mazurkiewicz v. Doylestown Hosp.*, 305 F.Supp.2d at 447-48 (E.D. Pa. 2004) (reaching the same conclusion as the District Court in this case based on an independent review of the cases). Review by this Court is unnecessary, since the federal regulations governing the application of EMTALA by hospitals are now clear on the issue of when EMTALA liability ends, and the District Court reached the identical conclusion as CMS based upon an independent evaluation of case law among the Circuit Courts.

D. EMTALA liability was never triggered in this case by the threshold requirement of a "transfer."

With respect to Mr. Morgan's presentation to the hospital, NMMC performed precisely the way that EMTALA encourages hospitals to do, by admitting Mr. Morgan for an additional nine days of inpatient care and services pursuant to the admission privileges of a treating physician, rather than transferring or discharging him from the emergency department due to his lack of health insurance. EMTALA liability was not triggered in this case because Mr. Morgan was *admitted* to a private room for significant, good faith inpatient care at NMMC.

"Transfer" is a term of art that does not refer to inter-hospital movement or admission of a patient, but is defined under EMTALA as "the movement (including the discharge) of an individual *outside the hospital's facilities. . . .*" 42 U.S.C. § 1395dd(e)(4) (emphasis added) (Appendix F, p. 80a) Once a hospital determines that a person has an emergency medical condition, the hospital must provide "such further medical examination and such treatment as may be required to stabilize the medical condition" before it can "*transfer* . . . the individual to another medical facility." 42 U.S.C. § 1395dd(b) (emphasis added). (Appendix F, pp. 68a-69a) Consequently, a key observation by CMS in adopting the final rule was the notation that the triggering act that gives rise to EMTALA liability is a "transfer" or "discharge" within the meaning of the statute, and not an inpatient admission. (Appendix H, pp. 99a-100a) Mr. Morgan was not discharged from the emergency department; he was admitted for inpatient care.

The Eleventh Circuit's affirmation of the District Court in this case is entirely consistent with its own precedent, wherein the Eleventh Circuit did not impose EMTALA liability when a patient was "admitted" to the hospital, but was not "transferred" according to the plain meaning of 42 U.S.C. § 1395dd(e)(4). *Harry v. Marchant*, 291 F.3d 767, 772-75 (11th Cir. 2002). Because Mr. Morgan was not "transferred" within the meaning of EMTALA, and there was nothing improper in his admission for inpatient care, EMTALA does not

provide the appropriate remedy for the Petitioner and review by this Court should be denied.

E. Petitioner's complaints in this lawsuit might be actionable under state medical malpractice law, and they are also subject to other federal oversight by CMS; however, they are not actionable pursuant to EMTALA under any circumstance.

Petitioner's remedy did not arise under EMTALA. The District Court was correct that Petitioner's claims resound in state medical malpractice law, and not under EMTALA. (Appendix D, p. 58a) Also, hospitals are required to provide inpatient care and treatment in accordance with separate and distinct federal statutory and regulatory mandates pursuant to the Social Security Act at 42 U.S.C. §§ 1302, 1395hh, and 1395rr, which are designed to ensure quality care for uninsured patients admitted to hospitals.

As indicated above, Mr. Morgan's treating physician did, in fact, attempt to treat Mr. Morgan's back pain at NMMC (although she did not believe any other treatment was required for his compression fractures), and her uncontroverted efforts were outlined in detail in the District Court's opinion on summary judgment. (Appendix C of Petition, pp. 10a-11a & n.7, 26a-27a) Any claim by the Petitioner that second-guesses the informed medical judgment of Dr. Haigh regarding treatment of Mr. Morgan's compression fractures clearly falls outside the scope

of EMTALA, since state medical malpractice law provides the appropriate and exclusive avenue for recourse. *See Harry v. Marchant*, 291 F.3d 767, 773-74 (11th Cir. 2002) ("The legislative history of EMTALA makes clear the statute was not intended to be a federal malpractice statute, but instead was meant to supplement state law solely with regard to the provision of limited medical services to patients in emergency situations. EMTALA was not intended to establish guidelines for patient care, to replace available state remedies, or to provide a federal remedy for medical negligence. Indeed, EMTALA expressly contains a non-preemption provision for state remedies.") (citations omitted).

Additionally, Mr. Morgan's inpatient admission was subject to an entirely separate area of federal oversight and regulation that attaches to patients admitted to hospitals from emergency rooms. (Appendix H, p. 100a) "[H]ospital's that fail to meet their obligations to provide quality care to inpatients may also face consequences affecting their Medicare certification under applicable CoPs [Medicare Conditions of Participation] at 42 C.F.R. Part 482." (*Id.*) These separate CMS regulations are promulgated pursuant to the Social Security Act, and serve as an alternative statutory regime governing inpatient care in hospitals. (*Id.*)

At best, the uncontroverted facts herein might give rise to a state malpractice claim. The Petitioner was not without an appropriate remedy under state

law, and review should be denied, since EMTALA clearly does not provide a remedy for the Petitioner.

CONCLUSION

Petitioner presented not even the slightest evidence that NMMC admitted Mr. Morgan for inpatient care and services in order to avert EMTALA liability. Even Petitioner's own expert agreed that Mr. Morgan's inpatient admission was not designed to avoid EMTALA liability. (Appendix C, p. 13a & n.9) In order to reverse the District Court's ruling in this matter, this Court would have to reach the untenable conclusion that NMMC provided in excess of $8,000 worth of emergency room care over the course of four and a half hours, and nine days of additional inpatient care and services at a total cost exceeding $24,000 (including care and treatment of compression fractures), simply as a mere charade. Logic and clear legal precedent dictate otherwise.

This Court should deny the Petition for Writ of Certiorari.

Respectfully submitted,

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